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ABSTRACT

This report is a selective analysis and assessment of quantitative data and field studies that reflect the economic role of the Academic Health Center (AHC) in the urban economy and in neighborhood revitalization. It describes the effect of a variety of cooperative efforts between local community organizations and AHCs, which usually include a medical school and a teaching hospital. The first part of the report describes revenue-creating activities of the Academic Health Center as a purchaser of durable and nondurable goods from a large number of industries, including construction, pharmaceuticals, and hospital supplies, and from local producers of commodities and services such as utilities, laundry, and food. This macroeconomic analysis is derived from a sample of AHCs in nine metropolitan centers (Baltimore, Boston, Chicago, Denver, Houston, Los Angeles, New York, Philadelphia, and St. Louis). The second part examines the role of eight urban AHCs in collaborative neighborhood development efforts, primarily initiated in the 1960s and located in Boston, New York, Baltimore, Pittsburgh, Indianapolis, St. Louis, Los Angeles, and Irvine (California). A concluding section examines the likely directions of such cooperative efforts in the decades ahead. Seven tables display supporting data, and an appendix discusses the concept of "export income" in the context of the urban economy. (JDD)

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THE
COMMONWEALTH
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REPORT OF THE TASK FORCE
ON ACADEMIC HEALTH CENTERS

CONTRIBUTING TO THE COMMUNITY

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THE
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REPORT OF THE TASK FORCE
ON ACADEMIC HEALTH CENTERS

CONTRIBUTING TO THE COMMUNITY

**The Economic Significance of
Academic Health Centers And
Their Role in Neighborhood
Development**

Report IV

THE COMMONWEALTH FUND

The Commonwealth Fund was established as a philanthropic foundation in 1918 by Anna M. Harkness. The name "Commonwealth" is derived from Mrs. Harkness' wish that the Fund's resources be used to enhance the common good. Her son, Edward S. Harkness, the Fund's president until his death in 1940, developed the Fund's basic program approach of identifying and helping to meet society's long-term health care needs. In 1925, the Fund also established the Harkness Fellowships Program under which young citizens of the United Kingdom, Australia, and New Zealand pursue graduate-level studies in the United States.

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CONTENTS

Members of the Task Force on Academic Health Centers	i
Statement of Purpose	iii
Introduction: The Plus Side	IV/1
The Economic Significance of Academic Health Centers and Their Role in Neighborhood Development	IV/4
I. A Metropolitan Focus	IV/8
II. Academic Health Centers and Community Development	IV/20
III. A Look Ahead—1987 and Beyond	IV/41

Tables

I. Magnitude of Health Care in Economies of Nine Metropolitan Areas, 1984	IV/12
II. Expenditures of Teaching Hospitals and All Hospitals in Nine Metropolitan Areas, 1984	IV/13
III. Health Research Income in Economies of Nine Metropolitan Areas, 1984	IV/14
IV. Growth of Health Care Industry in Economies of Nine Metropolitan Areas, 1976-1984	IV/15
V. Health Jobs in Metropolitan Economies, 1976-1984	IV/16
VI. Blacks and Hispanics Employed in Health Care, 1980	IV/17
VII. Health Sector Export Income and Multiplier Effect, 1984	IV/18
Appendix: The Concept of Export Income	IV/45

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STATEMENT OF PURPOSE

In the United States, academic health centers have made essential contributions to our society's unrivaled health care system. Now this system is going through a time of change and transition.

The centers, which usually include a medical school and a teaching hospital, serve as the base for medical education. They create significant advances in medical science and technology. They provide complex and crucial medical care. And, in many areas, they serve as regional resources for special services such as trauma units and intensive care of burn victims and premature infants.

The Task Force on Academic Health Centers was created to help focus and advance discussion of the effects of these changes on the missions, management and costs of academic health centers. It is convinced that, even as the system evolves, the three essential functions of Academic Health Centers—medical education, clinical research and care of the sick—must be preserved for the public good. The Task Force Reports have been prepared as contributions toward that end.

The Task Force was established in January 1983 by The Commonwealth Fund, a philanthropic foundation headquartered in New York City. It has representation from a variety of disciplines. Robert M. Heyssel, M.D., president of the Johns Hopkins Health System, is its chairman, and Jerome H. Grossman, M.D., president of the New England Medical Center, is the program director. Among its members are leaders of teaching hospitals and medical schools, economists and health service researchers, a former Secretary of Health, Education and Welfare and a former Secretary of Labor.

This report, *Contributing to the Community: The Economic Significance of Academic Health Centers and Their Role in Neighborhood Development*, is the fourth in a series put out by the Task Force and aimed at informing the public about emerging trends in the health care field and the public policy issues that will shape the field in the future. The first three reports, published in a single volume, are: *Graduate Medical Education Programs in the United States*, *Health Care for the Poor and Uninsured* and *The Future Financing of Teaching Hospitals*.

The report was prepared under the direction of a committee of the Task Force chaired by Eli Ginzberg, Ph.D. Other members were John T. Dunlop, Ph.D., and Virginia Weldon, M.D.

Acknowledgments

The Task Force acknowledges the assistance and consultation of Matthew P. Drennan and William J. Grinker in the research used in the preparation of this report.

In all cases, the statements made and the views expressed are those of The Commonwealth Fund Task Force on Academic Health Centers and do not necessarily reflect those of individual Task Force members, The Commonwealth Fund, Professor Drennan or Mr. Grinker.

INTRODUCTION: The Plus Side

The nation's Academic Health Centers (AHCs), which play such a leading role in supplying America with health care, medical training and research, perform other significant but little-recognized functions that profoundly affect the well-being of the residents of their communities.

As large institutions which are often situated in inner-city neighborhoods, AHCs are major employers of local labor. They attract doctors, teachers, researchers and students who become consumers in the local economy. They are a magnet for satellite laboratories, clinics and health-related service businesses. They are the focal point around which a variety of neighborhood development projects revolve.

Cooperation between Academic Health Centers and local nonprofit and for-profit enterprises has become a national phenomenon. It has enriched communities by bringing in dollars, increasing the amount of housing, improving educational services, upgrading neighborhood security and contributing to the better use of land. In some cases, this cooperation has rejuvenated surrounding neighborhoods.

In Baltimore, AHC and community cooperation has renovated housing and revitalized the area. In Cambridge, Massachusetts, it has rehabilitated housing, created a training program for medical clerical jobs and brought in acceptable ambulatory care. In St. Louis, it has redeveloped an inner-city neighborhood. In Pittsburgh, it has provided housing for the elderly and handicapped. In Los Angeles, it has resulted in the channeling of procurement contracts to local minority vendors. In Indianapolis, it has formed a development corporation that has initiated a youth training and employment program, housing for the elderly and industrial

development. In Irvine, California, it has, through a private developer, created a research-oriented biotechnology complex.

This report by the Commonwealth Fund Task Force on Academic Health Centers describes the effect of a variety of cooperative efforts between local community organizations and AHCs. It demonstrates by specific example the impact many AHCs have had and the potential for other communities to learn from such efforts.

In the course of its explorations, The Commonwealth Fund Task Force on Academic Health Centers determined that the question of the Economic Significance of AHCs calls for greater attention. The Task Force believes that the economic role of inner-city AHCs, in particular, is not well understood. Specifically, what is their contribution to gross product in local and metropolitan areas; their provision of employment opportunities, especially for minorities, and the participation of selected AHCs in neighborhood development efforts?

On April 9, 1985, the Fund's board of directors approved an appointment of a committee consisting of John T. Dunlop, Virginia Weldon and Eli Ginzberg, chair, to design and carry out this project. The committee, in turn, engaged two principal subcontractors. The task of William Grinker of Grinker, Walker & Associates was to develop a set of case studies of neighborhood development in which a local AHC had played a leadership role. The assignment of Matthew Drennan, professor of economics, New York University, was to collect and analyze the quantitative data by which the economic significance of the health care sector in selected metropolitan areas could be assessed, with a special focus on the role of the AHCs. The Conservation of Human Resources, Columbia

University, assumed responsibility for assembling national data that would provide a framework for the metropolitan analyses.

In preparing this report for publication, the committee received useful information and suggestions from other members of the Task Force, which helped broaden and deepen its perceptions of the role of the AHCs in local economic and neighborhood development. This assistance is gratefully acknowledged.

John T. Dunlop

Virginia Weldon

Eli Ginzberg, Chairman

Committee on the Economic Significance of
Academic Health Centers

The Commonwealth Fund Task Force on Academic
Health Centers

THE ECONOMIC SIGNIFICANCE OF ACADEMIC HEALTH CENTERS AND THEIR ROLE IN NEIGHBORHOOD DEVELOPMENT

For more than a decade, American society—government, employers, trade unions, insurers and the public at large—has been increasingly concerned with ways to decelerate the rise in medical care costs. This preoccupation with cost containment has eclipsed recognition of the other side of the balance sheet—the economic contribution of medical care providers. For instance, the ever-growing health care sector provides income and jobs for a substantial segment of the population. Little attention has been paid to the important role that the health market plays as a purchaser of durable and nondurable goods from a large number of industries, including construction, pharmaceuticals and hospital supplies, and from local producers of a wide range of commodities and services such as utilities, laundry and food. These revenue-creating activities by the health care sector are the subject of the first part of this report.

The second part examines the role of selected urban AHCs in collaborative neighborhood development efforts that, in most instances, were initiated in the 1960s. Except for sporadic reports and journalistic coverage, largely political in tone, this relatively recent experience has not been systematically studied and its implications for inner-city viability are not widely understood.*

* A detailed account of the central role of a medical school complex in a major urban redevelopment project may be found in a recent volume, *HERO-An Oral History of the Oklahoma Health Center*, by Robert C. Hardy (1985). This is a case study of institutional expansion that was encouraged by the local Chamber of Commerce and the economic development authorities, with little representation from the low-income population at risk of displacement. It should be noted that a considerable number of community hospitals, unaffiliated or only loosely affiliated with an AHC, have over the years engaged in neighborhood development efforts, in some cases antedating those studied in this report.

This report does not purport to be a comprehensive survey of the role of the AHC in the urban economy and in neighborhood revitalization; rather it is a selective analysis and assessment of quantitative data and field studies that reflect the broad economic reach of the urban AHC. The macroeconomic analysis presented in Part I is derived from a sample of AHCs in nine metropolitan centers. Part II, which describes and appraises efforts at neighborhood redevelopment, is based on detailed case studies of eight urban AHCs. The two samples overlap in five of the cases.

A National Perspective

National statistics on the health care sector provide a useful perspective from which to consider the urban sample we have studied. In 1985, the Federal government reported total national health expenditures at \$425 billion, constituting 10.7 percent of the gross national product (GNP) of \$4 trillion. Preliminary data for 1986 estimate a rise of health care expenditures to \$465.4 billion and of GNP to about \$4.3 trillion. This results in a modest increase of about one-tenth of one percent in the proportion of the health component.

Employment estimation is more complicated. There are two distinct approaches to calculating the contribution of the health care sector to the job market, and each approach produces a different estimate. One method is to include in the health work force all persons employed in the production of health care services irrespective of occupation, from professionals to support personnel. Defined this way by industry, employment in health care in 1985 exceeded 8 million. With the nation's total employment averaging 107 million, the health care sector provided approximately 1 out of every 13 jobs.

A narrower definition would count only those workers who are engaged in a distinct health care occupation requiring specific education or training. Using this more restrictive definition, one can identify a work force of health professionals, technicians and aides of about 5.5 million. The considerable difference between the two figures, 8 million and 5.5 million respectively, is accounted for by the several million employees who provide support services in the health care system, from telephone operators, maintenance workers and kitchen help in patient care facilities, to the thousands of clerks employed by health insurers and government agencies.

Here, the principal focus is the AHC, conventionally defined as a complex composed of a medical school, its principal affiliated teaching hospital, and at least one other health professional school. At present, the nation has 127 AHCs.

The Council of Teaching Hospitals (COTH) of the American Association of Medical Colleges (AAMC) in 1984 listed 356 hospitals as principal teaching affiliates of medical schools (exclusive of Veterans Administration hospitals). COTH accounted for more than 204,000 hospital beds (of a total of 1,021,000 general care beds), 869,000 personnel, and total hospital expenditures of just under \$36.5 billion.

The 127 AHC medical schools had total expenditures of slightly more than \$8.75 billion, including \$1.7 billion of research funding. The scale of their educational activities is reflected in the following student count:

Medical students	67,443
Residents	52,092
Graduates—Basic Science	18,204
Other students	77,469
Total	215,208

If one adds the expenditures of the 356 COTH hospitals to the expenditures of the medical schools, the total comes to \$45.2 billion. This figure understates the total outlays of the AHCs, since it does not include expenditures of the other health professional school(s) that are usually subsumed within a university's total budget. Even with this undercount, the AHCs were responsible for about 12 percent of total health care outlays in 1984.

I. A METROPOLITAN FOCUS

Since the nation's 127 medical schools are heavily concentrated in relatively few areas, mostly large urban centers, the foregoing national overview fails to capture the impact of AHCs on the communities in which they are located. Professor Matthew Drennan of New York University studied nine metropolitan areas containing one or more AHCs for the purpose of assessing in greater detail the AHCs' contribution to income generation and employment in their communities. The nine locations were selected with an eye to regional variation.

The cities sampled and the number of AHCs located in each are as follows:

Baltimore	2
Boston	3
Chicago	6
Denver	1
Houston	2
Los Angeles	2
New York City	7
Philadelphia	5
St. Louis	2

These 30 medical schools enroll about 29 percent of the 67,000 medical students in the United States. In fact, 20 percent of the medical students in the United States attend school in one of just four cities: New York, Chicago, Philadelphia and Boston. An even greater concentration of medical residents than of undergraduate medical students is found in these nine sites—34 percent of the national total.

Table 1 sets out the role of the health care sector in the economies of the nine metropolitan areas. With the exception of New York City, where the data relate only to the five boroughs of the city proper, the figures are for both the city and its suburbs, that is, the metropolitan area.

A marked variation is found between the leading site, Boston, where health care accounts for 12.4 percent of gross metropolitan product and the lowest, Denver, with 7.6 percent. Health care in the other seven areas falls within a narrower range—from 9.1 percent to 11.2 percent of local product.

Since the purpose of this analysis is to specify the role of the AHCs, particular attention is focused on the teaching hospitals in the sample. Table 2 indicates the major contribution of teaching hospitals to total hospital expenditures in these nine areas. The proportion ranges from a high of 78 percent in New York City to a low of just under 20 percent in Denver, with most falling between 40 and 50 percent. Restated, the teaching hospitals in these nine locations account for close to half of all hospital expenditures.

Another measure of the economic significance of the AHCs in these nine locations—beyond their educational mission and their patient care activities—is their sizable biomedical research effort. Of the approximately \$3 billion of grants awarded by the National Institute of Health in 1984, \$1 billion went to the AHCs represented in the sample. Table 3 presents the total amount of research expenditures in each metropolitan area. The five largest recipients in the sample attracted \$1.9 billion: New York, \$640 million; Boston, \$505 million; Philadelphia, \$299 million; Los Angeles, \$212 million; Baltimore, \$200 million. This represented

28 percent of the national total of \$6.8 billion (NIH plus other non-corporate).

The foregoing expenditure data reflect the important economic contributions to their respective communities of the health care sector, in particular the AHCs. Further confirmation of the vitality of the health care sector is found in Table 4, which indicates that total health care expenditures over the 1976-1984 period increased more rapidly than gross metropolitan output and far more rapidly than population. While much of the increase reflects inflation in general and medical care inflation in particular, the health care sector, with the single exception of New York City, outpaced the economy as a whole.

Another critical indicator of the significance of the health care sector is the employment data for the nine sites. Table 5 details the number of health jobs in the private sector compared to total private employment in 1984. The record of recent growth is especially impressive. In each area, except for Boston, the annual rate of increase for health jobs in the private sector surpassed the rate of total private job growth for the period 1976-1984. Table 6 indicates the particular importance of health care area for the employment of blacks and Hispanics. Census data for 1980 reveal that in five of the nine locations, health care accounted for an impressive proportion of minority jobs: from 12.5 percent in Philadelphia to 15.7 percent in Boston.

The literature on urban economic development places considerable emphasis on the attraction and retention of "export industries," viz. defense in Southern California, tourism in Florida, and—until recently—energy in Texas. Relatively little attention has been paid to the health care sector, and more particularly its cutting edge—the AHCs—as

an export industry. Table 7 sets out the "export income"* of the AHCs based on estimates of revenues generated by the performance of medical research, the hospitalization of out-of-town patients and the education of out-of-state medical students. The importance of the AHC multiplier effect is highlighted by the fact that, except for Denver, the total income produced was over \$1 billion per community, and in the case of New York City and Boston, it exceeded \$4 billion and \$3.5 billion, respectively.

In summary, the perception of the health care sector as an excessive consumer of resources must be tempered by the foregoing demonstration of its vital contribution to metropolitan economies. AHCs, which tend to be located in inner cities, have an especially important role in generating income for their immediate neighborhood, frequently a depressed area, and in providing jobs for minority populations. In fact, the health sector, and particularly the hospitals, have been the most effective portal into the mainstream for blacks and, more recently, Hispanics.

Moreover, as the tables indicate, the economic activities of the health sector outpace the general urban economy in years of prosperity and prove relatively resistant in periods of recession. Finally, the several intrinsic functions of the AHCs—medical education, health care delivery and research—channel a wide range of external funding streams into the metropolis and the immediate community. These have a "multiplier" effect that enlarges the urban income many fold.

* A brief discussion of the concept of export income and its estimation is found in the Appendix.

TABLE I
MAGNITUDE OF
HEALTH CARE IN
ECONOMIES OF NINE
METROPOLITAN AREAS
1984

Metropolitan Area	Total Health Expenditures (Millions of \$)	Gross Product (Millions of \$)	Health Expenditures as % of Gross Product
Baltimore	\$ 3,278	\$ 36,001	9.1%
Boston	7,494	60,423	12.4
Chicago	9,924	106,816	9.3
Denver	2,592	34,205	7.6
Houston	5,097	55,620	9.1
Los Angeles	15,157	140,470	10.8
New York City	16,225	144,300	11.2
Philadelphia	7,367	73,137	10.1
St. Louis	4,019	39,064	10.3
United States	387,400	3,663,000	10.6%

**TABLE II
EXPENDITURES OF
TEACHING HOSPITALS
AND ALL HOSPITALS
IN NINE
METROPOLITAN AREAS
1984**

Metropolitan Area	Teaching Hospitals (Millions of \$)	All Hospitals (Millions of \$)	Teaching Hospitals as % of All Hospitals
Baltimore	(7) \$ 665	(27) \$1,315	50.5%
Boston	(13) 1,323	(61) 2,617	50.5
Chicago	(17) 1,966	(91) 4,675	42.0
Denver	(2) 177	(18) 901	19.6
Houston	(5) 687	(41) 1,464	46.9
Los Angeles	(9) 1,441	(97) 4,474	32.2
New York City	(32) 4,306	(69) 5,502	78.3
Philadelphia	(17) 1,459	(64) 2,904	50.2
St. Louis	(6) 551	(40) 1,626	33.9

Note: Figures in parentheses indicate number of hospitals.

**TABLE III
HEALTH RESEARCH
INCOME IN ECONOMIES
OF NINE
METROPOLITAN AREAS
1984**

Metropolitan Area	Total Health Research* (Millions of \$)	NIH Research Grants (Millions of \$)
Baltimore	\$ 200	\$ 92
Boston	505	232
Chicago	185	85
Denver	62	29
Houston	143	66
Los Angeles	212	97
New York City	640	294
Philadelphia	299	137
St. Louis	127	58
United States	\$6,800	\$3,012

*Excludes internal research of corporations such as pharmaceutical firms and medical equipment firms.

**TABLE IV
GROWTH OF
HEALTH CARE INDUSTRY
IN ECONOMIES
OF NINE
METROPOLITAN AREAS
1976-1984**

Metropolitan Area	% Change, 1976-84		
	Health Care Expenditures	Gross Product	Population
Baltimore	131%	102%	5.7%
Boston	151	125	0.5
Chicago	140	65	1.4
Denver	169	156	9.8
Houston	232	134	27.1
Los Angeles	169	113	9.2
New York City	82	96	-3.8
Philadelphia	138	91	0.2
St. Louis	153	98	1.6
United States	157%	113%	8.1%

TABLE V
HEALTH JOBS IN
METROPOLITAN
ECONOMIES
1976-1984

Metropolitan Area	1984			Average Annual % Change, 1976-84	
	Health Employment, Private (Thousands)	Total Private Employment (Thousands)	Health as % of Total Employment	Health Employment, Private	Total Private Employment
Baltimore	74.6	777.4	9.6%	7.0%	2.2%
Boston	151.0	1,431.4	10.5	3.4	3.7
Chicago	199.4	2,441.0	8.2	3.4	-0.7
Denver	53.7	762.8	7.2	6.0	5.1
Houston	77.3	1,330.9	5.8	6.8	3.0
Los Angeles	239.3	3,270.8	7.3	5.6	2.8
New York City	239.4	2,898.0	8.3	3.9	1.0
Philadelphia	171.2	1,694.8	10.1	5.0	1.5
St. Louis	81.9	904.6	9.1	4.5	1.7

**TABLE VI
BLACKS AND
HISPANICS EMPLOYED
IN HEALTH CARE
1980**

Metropolitan Area	Black and Hispanic Employees		
	Health Care (Thousands of workers)	All Industries (Thousands of workers)	Health Employment as % of Employment in All Industries
Baltimore	27.0	215.0	12.6%
Boston	13.5	85.9	15.7
Chicago	62.7	704.7	8.9
Denver	8.3	104.8	7.9
Houston	32.0	413.4	7.7
Los Angeles	83.9	1,201.8	7.0
New York City	152.6	1,191.0	12.8
Philadelphia	40.3	322.0	12.5
St. Louis	20.1	144.0	14.0

**TABLE VII
HEALTH SECTOR
EXPORT INCOME
AND MULTIPLIER
EFFECT, 1984**

	(1)	(2)	(3)	(4)
	Number of Out-of-State Medical Students	Tuition Expenditures Out-of-State Students (a) (Millions of \$)	Hospital Expenditures Out-of-Town Patients (Millions of \$)	Share of All Hosp. Expenditures Attributed to Out-of-Town Patients (Percent)
Baltimore	471	7.5	\$105	8
Boston	1,312	21.0	209	8
Chicago	1,316	21.1	281	6
Denver	10	0.2	27	3
Houston	311	5.0	102	7
Los Angeles	130	2.1	224	5
New York City	3,275	20.4	660	12
Philadelphia	1,284	20.5	232	8
St. Louis	977	15.6	81	5

(a) Range \$12,000-\$20,000/yr.; computations based on \$16,000.

(b) Sum of columns 2,3 & 5.

(c) Based on estimates by Richard Knight and by Matthew Drennan.

(d) Column 6 multiplied by column 7.

(5)	(6)	(7)	(8)
Research Grants (Millions of \$)	Total Health Export Income (b) (Millions of \$)	Multiplier (c)	Total Income Generated from Health Export Income (d) (Millions of \$)
\$200	\$313	4.8	\$1,502
505	735	4.8	3,528
185	487	4.8	2,338
62	89	4.8	428
143	250	4.8	1,200
212	438	4.8	2,103
640	1,320	3.1	4,093
299	552	4.8	2,647
127	224	4.8	1,073

II. AHCs AND COMMUNITY DEVELOPMENT

As noted in the Introduction, Part II of this Report explores the role of selected AHCs that have engaged in neighborhood development projects during the past quarter of a century. While such development and redevelopment efforts have usually had a favorable economic impact by expanding jobs and income for neighborhood residents, they have also improved and enlarged the local housing stock and contributed to better use of land, improved health and educational services, greater security and other community goals.

The case studies, which were developed by Mr. William Grinker and his associates, include the following:

Boston	Harvard University, Harvard Medical School, Brigham and Women's Hospital
New York City	Montefiore Medical Center (Albert Einstein College of Medicine of Yeshiva University)
Baltimore	The Johns Hopkins Hospital
Pittsburgh	University of Pittsburgh School of Medicine and Teaching Hospitals
Indianapolis	Indiana University School of Medicine and Teaching Hospitals
St. Louis	Washington University Medical Center and St. Louis University Medical Center

Los Angeles

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University of California, Irvine, California
College of Medicine

Five of these case studies correspond in location with the metropolitan economic analyses developed by Professor Drennan; Pittsburgh, Indianapolis and Irvine were the exceptions. Also included in Drennan's sample were Philadelphia, Chicago, Houston and Denver, which were not studied for neighborhood development participation.

Rather than review individually and comparatively the accomplishments of the eight AHCs that are examined in these case studies, this assessment of the impact of their diverse neighborhood development efforts will be approached thematically. The Report addresses the following generic issues: Why did the AHCs become involved in activities that clearly fell outside their traditional orbit? What structures and processes were developed to accomplish their new objectives? What results did the AHCs achieve through their participation in neighborhood development? Finally, what is the outlook for further involvement of AHCs in such local development efforts?

Aware that the reconstruction of past events, especially in the absence of detailed records and documentation, is an invitation to subjective judgments, the Task Force submitted each of the eight case studies for review by an informed person with direct knowledge of the neighborhood development project(s) that were reported.

The following brief summaries of the case studies will provide an overview of the range of experiences on which our assessment of AHC community development effort is based.

BALTIMORE

The Johns Hopkins Hospital Health Center

Since their establishment in the late 19th century, The Johns Hopkins Hospital and The School of Medicine have been located in East Baltimore, where they constitute the chief landowner and employer. With the demographic shifts and urban deterioration of the 1950s and 1960s, the hospital adopted an aggressive policy of neighborhood property acquisition—largely residential—for possible future expansion; these holdings were gradually withdrawn from the housing stock but were not developed. In the racial riots of 1968, Johns Hopkins was a focus of generalized hostility in the surrounding black community. Two issues emerged as paramount—the need for local ambulatory health services and resistance to further encroachment by the medical institutions on residential property. Johns Hopkins responded promptly to the neighborhood demands defined by the Middle East Community Organization. To provide clinic care, it assisted the community in establishing a Health Maintenance Organization (HMO), which it ultimately took over when it was threatened by bankruptcy. With respect to land acquisition, the hospital committed itself to defined boundaries for institutional expansion.

Since these agreements of 1968, Hopkins and the adjacent community have achieved a growing sense of identity. In the past five years, the medical institutions have actively cooperated with a coalition of neighborhood, public, private, voluntary and business groups in projects to revitalize the area. Housing renovation has been a top priority. The hos-

pital has committed almost \$3-4 million to two major housing developments (Jefferson Court and McElderry Court) on property it owns. There has been minimal tenant dislocation and decisions have regularly and consistently followed community consultation. However, the proposed rehabilitation of an even more seriously deteriorated area is problematic because of the inability to produce a satisfactory financing/development plan in the current economic climate.

BOSTON

Harvard University, Harvard Medical School, Brigham and Women's Hospital

Harvard's interaction with the community adjacent to its medical school began in the late 1950s—early 1960s over the issue of its master plan for the development of an expanded hospital-medical school campus. Community resistance—mobilized and supported by Harvard student activists—arose over the acquisition of property by the medical school in neighboring Mission Hill, a residential area. Community organizations were established to represent two basic interests of the population: encroachment on existing housing (the Roxbury Tenants of Harvard) and responsibility of the teaching hospital for the delivery of health services to the community (the Mission Hill Health Movement). Reluctantly, the institutions agreed to limit expansion and to replace housing lost through institutional construction by undertaking new housing development in conjunction with the Roxbury Tenants, for which the University underwrote front-end costs and which it continues to subsidize. Overall, 775 units have been rehabilitated and are being managed under a variety of joint arrangements with community groups. Besides real estate development, the institutions have undertaken a number of other community-oriented activities in response to the health services

needs of the neighborhood. These include the development by the new Brigham and Women's Hospital of improved, more acceptable ambulatory care and the operation of two community health clinics. More recently, Brigham and Women's established a training program for medical clerical jobs that attracts and ultimately provides employment opportunities for community residents.

NEW YORK

Montefiore Medical Center

The impressive post-World War II transformation of Montefiore from a chronic disease hospital to a major academic medical center has, paradoxically, coincided with extreme neighborhood deterioration, which threatened to advance to the doorstep of the institution. Opting, nevertheless, to remain in the neighborhood, the hospital developed a master plan for plant improvement and expansion. Foreseeing the need for good community relations, Montefiore took the landmark step (for an AHC) of organizing a Community Advisory Board with representation on its Board of Trustees. Nevertheless, approval of the first phase of its improvement program, the construction of a multilevel parking garage, engendered serious conflict and, although finally resolved by compromise, sensitized the hospital to the urgency of overcoming community hostility.

This perception catalyzed a program of local improvement and assistance that has concentrated on two major areas: stabilization of the neighborhood and direct economic development. To implement these efforts, Montefiore created two nonprofit organizations—the Mosholu Preservation Corporation (1981) and Bronx Community Enterprises (1983). Each has received substantial funds from the hospital trustees and is structured

to assure significant community involvement. The neighborhood preservation corporation's strategy has included direct acquisition and rehabilitation of dilapidated properties and technical/financial assistance to landlords and tenants interested in upgrading their buildings; a youth employment program, and a security system for local merchants linked to that of the hospital. Bronx Community Enterprises has focused on expanding local business and employment, primarily by leveraging Montefiore's considerable purchasing power. More recently, it has moved into new business development. Montefiore's aggressive approach to community development has been unique by virtue of the heavy involvement of the hospital's trustees in its organization, funding and progress.

ST. LOUIS

Washington University Medical Center

Since the early 1970s, St. Louis has experienced a remarkable economic resurgence to which its two medical centers have contributed both directly and indirectly. Washington University, in particular, was one of the earliest AHCs to take a leading role in reversing a deteriorating environment. Resisting pressures to move, Washington University Medical Center chose to remain in its declining inner-city location with the explicit understanding that its future viability would depend upon a major commitment to neighborhood redevelopment.

Through the creation of the Washington University Medical Center Redevelopment Corporation, a wholly-owned nonprofit subsidiary, the medical center has succeeded in attracting more than \$400 million in private, public and institutional investment in the area, creating 3,500 new jobs. In addition to these economic projects, four major housing projects containing 375 units have been constructed. The relocation of 500 house-

holds necessitated by the redevelopment efforts was eased by the construction of a large housing complex for the elderly. The Medical Center has provided more than \$3 million to the Redevelopment Corporation, whose role has been that of overseer, facilitator and coordinator of redevelopment for the entire area; it has itself not engaged in direct development. The project is noteworthy for its avoidance of serious conflict with area residents and in 1986 was renewed for an additional 10-year period.

St. Louis University Medical Center

Similarly committed to the inner city, St. Louis University in 1976 mobilized several of its affiliated health institutions to form the Midtown Medical Center Redevelopment Corporation for the purpose of acquiring property for institutional expansion and of fostering neighborhood redevelopment to create a racially and economically integrated community. The corporation focused on housing rehabilitation, physical improvement of the area and enhanced security. But serious community hostility has been generated by the threatened dislocation of residents through the power of eminent domain and by various actions and regulations of the corporation, which have been interpreted as moves that would drive families out of the neighborhood. The corporation has sought to foster youth employment and training and has created a neighborhood association to serve local residents. With funds of about \$10 million (\$3 million of it from St. Louis Medical Center and associated institutions), the corporation has rehabilitated or constructed more than 300 units of housing. Additional private investment has gone to hospital expansion and rental projects. However, conflict between the objectives of the member hospitals and community reaction to the actions of the corporation have destabilized the effort. The future neighborhood role of St. Louis University is uncertain.

PITTSBURGH

University of Pittsburgh School of Medicine/University Health Center

Interaction with its surrounding community and participation in community development by the University of Pittsburgh School of Medicine and its affiliated hospitals have been a byproduct of the rapid growth of the university following its conversion to a state-related institution in 1966. Plans for major physical expansion in an area already heavily populated with institutions evoked strong resistance from two community-based organizations (People's Oakland and Community Human Services), which succeeded in halting the university construction program by appeal to the city government's review process. As a result, a public forum for development planning and an official long-range multi-sector development planning process for the area were created, with university and hospital representation on both. In 1980, the nonprofit Oakland Planning and Development Corporation was established to promote neighborhood revitalization. It has concentrated on housing rehabilitation with priority given to the needs of the elderly, the handicapped and the mentally disabled. At present, a second phase of housing, and possibly commercial, development is projected. For this, a development fund has been established with major financing from the university and the University Health Center, an umbrella organization incorporating the School of Medicine's affiliated hospitals and outpatient clinics.

The medical school itself has not had a prominent role in these collaborative activities. The lead has been taken by the university. However, the affiliated hospitals have been directly involved, both individually and through the University Health Center.

LOS ANGELES

University of Southern California School of Medicine

The USC School of Medicine has experienced little political interaction or contention with the surrounding community. It is located in East Los Angeles and for a century has operated as its primary teaching facility the Los Angeles County Hospital, a renowned 1500-bed institution serving a large indigent population. The School of Medicine's expansion from one building to 11 during the 1960s was accomplished peacefully, perhaps an accident of topography, and it has escaped overt conflict over its role as principal provider of care to many of the poor of Los Angeles. This may change with the development by USC of a new private hospital in conjunction with National Medical Enterprises (NME). The new hospital has evoked concern that staff resources will be deflected from the County Hospital. USC's interest in enhancing the economic well-being of the community has generated creative programs to recruit minority students for health careers and extensive training programs for allied health professionals. The latter programs attract local residents, many of whom are eventually hired.

Charles R. Drew Postgraduate Medical School/ Martin Luther King Jr.—Drew Medical Center

Drew Medical School is distinctive among the institutions studied, for its age (it is the youngest), and, more importantly, for its history. The medical school and Martin Luther King, Jr. General Hospital are products of the Watts riots of 1965 and were established as the focal point for intensive redevelopment of Southwest Los Angeles. The medical school was explicitly mandated to carry out medical education, clinical services,

and research oriented to the health needs of an underserved minority population.

Addressing the economic needs of the community has been seen as a part of the school's responsibility to improve the local population's health. An early, if unsuccessful, effort was the organization of a food cooperative by the Department of Community Medicine. In 1982, through the efforts of the Office of the Dean, the Drew Economic Development Corporation was established as a nonprofit organization. It was financed with operating subsidies and in-kind support from the medical school as well as from government and foundation resources. The corporation has leveraged the economic resources of Drew—targeting procurement contracts to community vendors and opening the campus bookstore as a business enterprise. Its most ambitious effort, currently under way, is a housing and economic development project for mixed-income working parent families, sponsored jointly with L.A. County, which has committed funds for property acquisition and land clearance.

INDIANAPOLIS

Indiana University School of Medicine and Methodist Hospital

Both Indiana University and Indianapolis' largest hospital, Methodist Hospital, have worked since the early 1970s to combat urban blight. Indiana University, whose Indianapolis campus is merged with that of Purdue (IU-PUI), has collaborated actively with a community development corporation, Business Opportunities Systems, Inc., in the development and expansion of minority business, the rehabilitation of midtown real estate and the construction of a housing project for the elderly.

Methodist Hospital, a large community hospital affiliated with the medical school, committed itself as far back as 1968 to the establishment of a community development corporation to sponsor local housing, commercial and industrial projects. Although the plan was not implemented until 1977, the hospital took the initiative to create, in conjunction with two community groups, the New North Development Corporation, to which it has contributed \$250,000. New North's projects have included a youth training and employment program, housing development for the elderly, a homeowner's maintenance and improvement program and, more recently, industrial development. The corporation, in turn, has helped the hospital's expansion program acquire needed land and relocate tenants.

At present, the various organizations—Methodist Hospital, IU-PIU, the two community development corporations and the medical school—are joined in an ambitious effort to establish a major med-tech industrial park on a deteriorated site abutting Methodist Hospital. It is uncertain, however, whether the needed financial and institutional support can be marshalled, and whether there is sufficient demand by U.S. and foreign companies for still another major biotech center.

IRVINE

University of California-Irvine, California College of Medicine

The University of California-Irvine (UCI), is a relatively new institution that has developed over the past two decades simultaneously with the new community of Irvine, of which it is an essential part. The primary teaching hospital of the medical school (the County Hospital) is located 20 miles away in Orange, a far less affluent community with a population containing a large proportion of indigent Hispanics. Eco-

nomic development activity by UCI however, has not focused on this community; it has involved collaboration with the Irvine Company, a private developer, to create a major research-oriented biotechnology complex with a community hospital in the city of Irvine.

Community pressures for a local hospital, the fiscal problems of the UCI Medical Center in Orange, state-local politics and the desire of many members of the medical school faculty for a new hospital have combined to impel UCI into an agreement to staff, as a teaching facility off-campus, a proprietary community institution (owned and operated by American Medical International). It will include no research facility and the university will have little control over it. The potential diversion of faculty resources from the medical center at Orange, and abandonment of the initial strong commitment of the school to social medicine and the care of the indigent, have evoked considerable resistance to this move. As of now, UCI has promised to continue to operate the County Hospital at its previous level of excellence. Whether, in fact, scarce resources will not gradually be withdrawn remains to be seen.

Why Did the AHCs Become Involved in Neighborhood Economic Development?

Several of the efforts reviewed here had their roots in the late 1960s when the civil rights movement was at its height and the white leadership recognized the desirability of acting to dampen the inner-city racial unrest, which was reaching the point of explosion. The deterioration of many inner-city neighborhoods was so far advanced that the trustees of some AHCs seriously considered abandoning their old plants and relocating in the suburbs. A few AHCs actually did move, but most inner-city AHCs chose to continue operating at their long established sites, close to large aggregations of the urban poor.

Many of the AHCs that chose to remain had to expand and improve their facilities to meet enlarged responsibilities for education, research and patient care. This often brought them into conflict with the residents of the immediate neighborhood over the alternative uses of scarce space, chiefly the preservation or destruction of some or much of the existing housing.

For the most part, our case studies reflect the establishment of new, joint efforts between an AHC and one or more neighborhood groups seeking a *modus vivendi* to accommodate part, if not all, of the medical center's expansion program and at the same time contribute to neighborhood improvement primarily through rehabilitation of, and additions to, the housing stock.

In addition to the availability of substantial Federal urban renewal funds, these projects received assistance from state and occasionally local government in the form of grants, loans, tax abatements, zoning revisions and the use of the power of eminent domain.

By tradition and practice, AHCs and their principal affiliated hospitals were inward-looking institutions whose interests and resources were focused essentially on their missions of higher education and the advancement of medicine. Their endowments were, for the most part, narrowly circumscribed, and their boards and chief executive officers were preoccupied with finding resolutions to changes that impinged upon the pursuit of their primary mission. Almost without exception they moved with deliberate caution before taking the plunge into a neighborhood development project.

From the point of view of corporate responsibility, neighborhood development with its shaky economics and often Byzantine politics hardly constituted the safest investment for the institution's reputation or its endowment funds. Still, the large voluntary teaching hospitals that are the backbone of many inner-city AHCs had to be able to attract both private-pay patients and an array of professionals into a neighborhood that increasingly scared away such people. Arresting the further decline of the neighborhood became a precondition for the continued viability of the AHC.

The AHCs had another objective. Faced with the urgent need for expansion, many AHCs discovered that unless they were able to neutralize the opposition of the community, or better still, to elicit its support, construction plans might have to be put on hold, not for a few months but for years. Most difficulties between the AHC and the neighborhood related to the threatened loss of local housing to make way for the medical center's expansion.

At the same time, many other objectives engaged the AHC and the organized community. Both were concerned about neighborhood deterioration, although they often differed as to the causes and the cures. The fact that each wanted to arrest deterioration and to create conditions that would lead to neighborhood stability and improvement did not imply that the AHC and the local community agreed on the preferred ways to accomplish the desired turnaround.

Although many traditions initially blocked the inner-city AHCs from entering into neighborhood development, countervailing forces in the late 1960s encouraged the more venturesome ones to rethink their position and their actions. Among the most important were: their conviction

that a positive response to the civil rights movement was a moral imperative; their perceived self-interest in stabilizing the local environment to assure safe access for patients and staff; the availability of public funds for redevelopment, and the realization that failure to gain the acquiescence and support of the local community might delay indefinitely the expansion plans that were on the drawing board.

How Did the AHCs Become Collaborators in Neighborhood Development?

Despite the wide variety of neighborhoods and approaches to neighborhood development, one can discern a common pattern of evolution in most neighborhood development organizations. These organizations—and, by extension, their partnerships with other organizations—have tended to evolve in three stages.

First, there is a period of organizing, advocacy and confrontation; second, a growing collaboration among the neighborhood, local organizations and local government. The collaboration usually focuses on housing development, during which the neighborhood group acquires increasing sophistication in the details of real estate and construction. Often the organization and its partners move into complex public-private financing arrangements and branch out beyond housing into a third stage, joint ventures such as commercial or industrial development. Not all community-based organizations reach the third stage, although by now dozens of neighborhood groups around the country have established an economic development track record. However, as funds for housing development have declined, many more have begun to structure commercial or industrial real estate ventures.

Nearly all of the AHC/neighborhood collaborations in the sample followed, at least broadly, this development sequence. In the case of the relationship between Brigham and Women's Hospital and the Roxbury Tenants of Harvard, or the relationship between The Johns Hopkins Hospital and the Middle East Community Organization, only the first two stages were completed, but they represented classic examples of this evolution: a period of militancy and distrust followed by collaboration on housing issues. In the experience of St. Louis University and the Midtown Medical Center Redevelopment Corporation, the first two stages tended to be fused: organizing and militancy occurred primarily after some housing rehabilitation had begun. But in all three instances, there appears to be little interest in, or momentum for, advancing to the third stage of development. In fact, these partnerships seem to be stalled.

The cases of Pittsburgh and Drew, however, display some evidence of a move into the third stage of an economic development agenda, such as has transpired at Montefiore in New York City and, in a different style, at Washington University in St. Louis. Montefiore's business assistance and purchasing program requires sophisticated linkages between the AHC and the public and private sectors and reflects a carefully crafted approach to the retention and expansion of enterprises in a difficult neighborhood. The Washington University project, functioning as facilitator and coordinator, has had broad indirect effects in stimulating job creation and investment by the private nonprofit and for-profit sectors. In Watts (Drew) and Pittsburgh, matters are less far along, though the goals of both projects involve the same combination of economic development objectives and public-private financing that characterize stage-three joint development efforts.

Some Development Efforts Pause

The explanation of why some development efforts appear to stop at stage two while others advance to stage three involves more than simply the imagination, effectiveness and objectives of the leadership. As neighborhood groups' partnership relationships with other organizations develop, they reach a point where they need to grow and diversify in order to maintain the momentum that they previously generated. As neighborhoods improve, cooperative relations expand and more peaceful conditions prevail, the emotion and ideology that fueled the early momentum can begin to fade. Unless the initial projects expand and point to new potential, they lose their hold on the neighborhood.

Besides, the development needs of the AHCs are not boundless. In many instances, their collaboration with neighborhood groups has accomplished nearly all of their initial objectives. Unless they perceive new needs or opportunities, they have little reason to continue the earlier collaboration. Often—but by no means always—commercial or industrial development represents a new opportunity.

This brings to center stage the two exceptional cases of Indianapolis and Irvine. In both, the cooperative ventures are focused on economic development, with little or no housing involved. In Indianapolis, Indiana University has been working for some years with a local minority organization on housing-related issues, and the development partnership is approaching the third stage. In the case of Irvine, with its affluent population, the housing issue has never arisen. Rather, the perceived need is for a community hospital adjacent to the campus to fulfill the potential of the scientific and particularly the biotechnological enterprises that are being encouraged to locate there. Opposition to the construction

of the hospital by American Medical International (AMI) relates to the threat of deflecting the faculty's interest and time away from caring for indigent patients at the public hospital in Orange, a community 20 miles distant, which has been the medical school's primary teaching facility throughout the school's existence.

The role of the AHC in neighborhood development has tended to follow an evolutionary course, often beginning with confrontation or at least benign neglect, then moving into the provision of grants or in-kind support and eventually expanding to include investments in land and loans of talent and capital. In addition to providing "up-front" cash, usually ranging from a half-million to two million dollars, the AHCs have often made further contributions by advancing capital for land acquisition and sometimes providing, for a period of time, an important share of the community group's operating budget.

It is important to emphasize once again that the AHCs' initiatives in neighborhood development in the 1960s and 1970s were, without exception, limited undertakings. Large universities and nonprofit teaching hospitals, notwithstanding their often sizable endowments, did not feel free to switch large sums to efforts at stabilizing their environment even when they recognized that such a goal promised to make their existing and future investments more secure. Their collaborative efforts were modest undertakings, but on occasion these yielded substantial returns both to them and to their neighborhood.

A Multifaceted Assessment

This abbreviated account tells of the experience, in eight locations, of AHCs that became involved in neighborhood development during the past two decades. It is necessary to assess these efforts within the context

of a distinct time frame. Most were launched and carried out in a period when Federal funds for urban rehabilitation were available for leveraging. Such funds played a crucial role in Boston, New York, Baltimore, Pittsburgh, St. Louis and Los Angeles. It is noteworthy, however, that the disappearance of Federal funding has not deterred several of the AHCs and/or their community action partners from seeking state, local and private funds and continuing their joint development efforts. This is true for the second stage of neighborhood development in Pittsburgh, the use of private sector funds in Los Angeles and Irvine, the long-term (10-year) reauthorization of the Washington University project, and the potential tapping into industrial and philanthropic sources in Indianapolis to get the biotechnology center under way.

With the advantage of hindsight one can identify a number of forces that appear to be crucial in stimulating neighborhood development activities and in contributing to their success. On the community side, neighborhood militancy must be given heavy weight. An inner-city AHC is much more likely to contemplate departures in its programming and operations if it finds itself confronted by neighborhood opposition to its plan for land acquisition, demolition or new construction. The existence of a determined local opposition is likely to stimulate the AHC to explore new approaches to achieve its ends, including collaboration with a community organization(s) in a neighborhood development project.

Other factors may be significant, such as the AHC's geographic proximity to a residential neighborhood, the competence of the neighborhood organization, the interest and concern of the larger community in the revitalization of the neighborhood and the values of the AHC's leadership. All these, however, are less important than the militancy with which the local action group confronts the AHC.

Similarly, a number of institutional conditions, embedded in the organization of the AHC and its university relationships, may ultimately determine whether a neighborhood development effort is likely to be launched and, if launched, whether it will succeed. Two such conditions are crucial: 1) a clear perception by the AHC of its expanded mission and 2) a clear definition of responsibility for taking action.

Response to Challenge

Many inner-city AHCs were faced with deteriorating neighborhoods that threatened their ability to attract and retain an optimal flow of affluent patients and to house students, nurses and other staff in the immediate vicinity. Only a few responded to the challenge. They did so by transcending their traditional functions of education, research and patient care and entering into cooperative housing and economic ventures with one or another local activist organization. Those two enterprises managed to combine the goals of the AHC with the often quite different goals of the local organization. To commit endowment income to such development activities was not an easy decision for the administrative leadership and the trustees of an eleemosynary institution. Those who did usually had a vision of where they wanted to be some years in the future. While controlling their risks, they opted to go ahead.

Secondly, clear lines of responsibility are essential in order to take the requisite action once the decision has been made. Medical schools and teaching hospitals are often poorly structured for effective governance and decision-making. They work through multiple lines of authority and extended consultation. Frequently, the board of trustees of the parent university retains sole or concurrent decision-making power, and in such cases negotiations with outsiders can be difficult and prolonged. On the

other hand, some large teaching hospitals can move expeditiously once their board makes a decision to do so. A hospital, as a long-time provider of health care services to the local poor, is usually viewed as a more friendly institution than a major university, which, in general, has fewer interactions with the adjacent population.

Additional institutional factors that make a difference include the quality of the medical center's leadership, the breadth and depth of its strategic planning and the willingness of the AHC to experiment with new types of financing arrangements that may provide the cash flow needed to support the development plan.

A final observation: The experience of the urban AHCs that we have studied suggests that nonprofit institutions are as vulnerable as for-profit institutions to major changes in their environment. If they are tired and hidebound, they can be silent partners to the deterioration of their surroundings and can endanger their own future. We have identified a number of AHCs that ventured into untried relationships with local community groups. For the most part, they benefited from this new and unconventional role. They contributed to the improvement of their neighborhood and helped ensure their own future.

This analysis of the economic significance of AHCs and their selective efforts to enter into community development projects clearly reveals the interactive effects of macrosocietal trends, the rapid expansion of the health care sector, and community activism that prevailed during the last two decades.

III. A LOOK AHEAD—1987 AND BEYOND

In several notable instances, the ability of AHCs and local nonprofit and for-profit institutions to work together has had an enormous impact for the benefit of all these institutions, their communities and the people who live in them. This concluding section examines the likely directions of such cooperative efforts in the decades ahead.

A number of developments have serious implications for further joint AHC-community efforts:

- The Federal government's ability to provide funding for large-scale social programs such as urban renewal and expanded health care services will be seriously restricted given the budget deficits that have accumulated and the difficulty of reducing the shortfalls.
- The militancy of the civil rights revolution has moderated, reducing the pressures on white leadership to respond to the urgent needs and demands of poor urban blacks. While minority activism may regain momentum at some later time, there is no sign that this will occur in the years immediately ahead.
- The rate of change in the health care sector is accelerating, and many of the changes will continue to impinge on the urban AHCs. Among the trends are the shrinkage in the numbers of inpatient beds and admissions; the expansion of ambulatory sites; horizontal and vertical integration of providers and services; intensified price competition; reduced or, at best, level funding for graduate medical education and biomedical research; and a growing need to find alternative ways of paying for charity care.

- As the AHCs diversify to compensate for the decline in inpatient utilization and facilities, they will provide fewer entrance jobs for allied health personnel and support workers, a large number of whom have been recruited from minority groups.

The outlook is uncertain for the continuing partnership of urban AHCs in neighborhood development projects. There are several deterrents: the limited amount of Federal funds to support such efforts; the preoccupation of the AHCs' leadership with the need to meet the new service challenges they face; the loss of momentum in local activist groups, and the difficulties of identifying new projects of benefit to both parties.

But other forces hold out hope that the momentum for successful partnerships has not been exhausted. The case studies demonstrated the ability to attract private capital and philanthropic investments for the upfront money needed to underwrite a number of development projects. At the same time, some Federal urban renewal money is still available and state and municipal governments are able to assist well-designed and well-supported development efforts.

Moreover, a range of opportunities exist for future joint projects, other than highly capitalized housing and area rehabilitation, that hold promise for enhancing the local environment. Among them are: improved health care services to the poor; drug control and treatment programs; programs to make the local schools more functional; training and retraining courses aimed at improving the employment prospects of the local population and economic linkages between local businesses and the AHC.

A final observation: Once the leadership of an AHC has entered into a constructive partnership with a local community group, it is unlikely ever

again to ignore the people and the problems in its immediate environment. It may not be able to help more than a portion of those who need help, but it will keep trying now that it has recognized the importance of a stronger community. And at the same time, community organizations have learned that they can have a strong and constructive partner in a local Academic Health Center.

APPENDIX

The Concept of Export Income

In urban and regional economics, the analysis of the economic base (i.e. the structure of the urban economy) and economic growth focuses upon the trade multiplier, a concept borrowed from Keynesian economics. The fundamental idea is that all economic activity in an urban area can conceptually be split into two components:

- (1) the export or basic component, and
- (2) the local or non-basic component

The export component is the "exogenous" or independent part of the economy, being driven by demand outside the urban area. The local component is the dependent part of the economy, being driven by the size and prosperity of the local market.

In Keynesian economics, total national income is some *multiple* of the exogenous components, investment and government expenditures. Similarly, in urban economics, total urban income is some multiple of the exogenous export income.

Export income refers to dollars drawn into the urban area from outside. "Outside" can be the next county, the next state, or some foreign country. No distinction is made or, indeed, is relevant as to where outside the dollars came from. Similarly, export income can result from the sale of locally produced goods to non-local buyers (e.g. aerospace sales from Los Angeles area firms to the Defense Department) or the sale of locally produced services to non-local buyers (e.g. New York law firms' charges to clients in other cities).

The social security payments and pensions received by residents of St. Petersburg or Phoenix represent a significant export income for those places. True, viewed nationally, they are transfer payments, but for the local area they represent an inflow of income that is spent and respent and this has a multiplier effect on the local economy. Likewise, the medical school tuition of out-of-state students, the hospital charges of non-local patients, and the medical research grants from the Federal government and non-local foundations all represent export income for the urban economy.

Just as Keynesian multipliers have been estimated empirically, so have urban multipliers. Richard Knight, in his book, *Employment Expansion and Metropolitan Trade*, estimated multipliers for over 300 metropolitan areas in the United States. Not surprisingly, he found that larger (i.e. over two million in population) metropolitan areas that are more self-contained economically and have areas with *relatively* less outflow of income to other areas and that are *relatively* less dependent on imports, have larger multipliers than small metropolitan areas. In my own econometric work on New York City and the New York-Northeastern New Jersey metropolis, I most recently estimated multipliers of 3.1 (the city) and 5.0 (the metropolitan area). The city multiplier is smaller because so much of the income generated in the city is spent and respent outside the city by commuters.

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